Fostering Health North Carolina

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One goal of the Fostering Health North Carolina Initiative is to improve recognition, assessment, and response to trauma among foster children. The following are some pearls learned by a pediatrician who is part of the Fostering Health North Carolina state team about how to make pediatric practices more trauma-informed.

First, there is no one-size-fits-all model. A "Foster Care Medical Home" in the state of North Carolina can take many forms.

Second, identifying dedicated staff members within each partner agency (doctor's offices, the local Division of Social Services [DSS], local Community Care of North Carolina [CCNC] "network staff") and creating bridges between the agencies who support patients, families, and the clinical staff caring for them is critical. We cannot work in silos. We must communicate our shared goals and continue conversations.

Third, strong collaborations between stakeholder agencies and individuals require flexibility. For example, in Guilford County there is a "DSS Clinical Unit" dedicated to performing a mental health triage: every child in foster care above the age of 4 years is referred to the Clinical Unit for a Comprehensive Clinical Assessment (CCA) upon entry into foster care to determine what mental health diagnoses are present and what type of therapy is indicated. This is often the first step in identifying how many adverse childhood experiences (ACEs) a child in foster care has already accumulated. Most counties in North Carolina do not have a Clinical Unit and instead must rely on physicians, social workers, or even foster parents, to assess children's mental health needs and seek appropriate referrals.

The Real Experience of Medical Practices Trying to Implement Trauma-Informed Practices

It takes time—time to develop protocols, time to identify all the stakeholders, time to educate ourselves, our colleagues, and specialists about trauma-informed care, and then *extra* time during office visits or phone calls to share that education with foster parents on the front lines.

It is complicated—the DSS legal jargon and mandates must be learned by medical providers and vice versa for the collaboration to work.

It takes patience—counties and Social Service Departments are big organizations. Everyone needs an opportunity to escape the hustle and bustle of a typical day at work to really get to know what resources and education materials are already available. Medical providers in North Carolina who are not accustomed to utilizing their CCNC Provider Portal and the NCPeds.org website for reference need reminders on how to access those resources. The Provider Portal is an application provided to improve patient care and care coordination for North Carolina Medicaid recipients. Providers in primary care practices, hospitals, and other settings may use this secure portal to access care team contact information, visit history, and pharmacy claims history for their Medicaid-enrolled patients. Population management and quality reporting is also available for CCNC practices. Information gathered from the portal is practically essential for providers caring for children in foster care because most come without prior medical records. The NCPeds.org website's Fostering Health Initiative tab includes a library of resources meant to guide stakeholders through every aspect of caring for

children in foster care. Developing a Foster Care Medical Home without it would be reinventing the wheel.

It takes training—then re-training. Scheduling patients, clinic flow, sharing of information, consents, billing … all areas of a practice must become aware of how caring for children in foster care is different. Often the first barrier to overcome is the idea that children in foster care should be evaluated and treated "just the same as all patients." The practical logistics of developing a Foster Care Medical Home that is trauma-informed require some commitment.

It takes teams—no one could do this work alone. Taking care of children and youth in foster care is not just about having *any* medical provider quickly fill out the required forms, although this is, admittedly, a cumbersome requirement and perhaps a reason why some practices choose not to see children in foster care. Keeping up with current DSS social worker names and foster placement addresses seems like a full-time job, especially with the significant number of children placed out of county. Assuring that children and youth are getting in to appointments with trauma-informed providers quickly, on top of all the other arranging that must go on (school enrollment, visitations, court hearings) can easily drop down on the priority list of a foster parent or medical provider. Assuring that families get the appropriate evaluations and therapy modalities is often left up to the DSS Foster Care Social Worker, who may have little to no training themselves on how Trauma (with a capital T!) in children, actually manifests.

Specific Actions Taken to Foster a FCMH Program at Cone Health

The creation of a collaborative model between Guilford County DSS and the pediatricians providing primary care services at Cone Health was a years-long process that continues to evolve. The following is a simplified To-Do List of how we accomplished our Foster Care Medical Home program: 1) identify a physician champion among the staff pediatricians at the clinic as a "Foster Care Medical Director," with protected time devoted to developing and continuing collaboration for population-based care of children in foster care in Guilford County; 2) develop templates for use in the electronic medical record, so that all clinic providers, even Resident MD learners, can complete Initial Foster Care Visits appropriately; 3) make arrangements to continue to accommodate timely appointments for children entering into foster care, even if the practice must close to new patients due to high patient volume; and 4) meet bi-monthly at the medical practice to collaborate with the Practice MD (FC Medical Director), North Carolina Department of Social Services (DSS) supervisors, DSS Clinical Unit Director, Health Department Child Welfare nurse, Integrated Behavior Health clinicians (clinic-employed LCSWs who can be introduced by warm handoff to do same-day screenings or discussions and provide resources to foster parents), Patient Care Coordinator (BSW), and Local Care Managers (Care Coordination for Children, CCNC).

Children and youth in foster care make up one of the most vulnerable populations in our society. The challenges of caring for them may be daunting or seem overwhelming, but as Arnold Palmer once said, "The most rewarding things you do in life are often the ones that look like they cannot be done." NCMJ

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